Financial Agreement

I,_____, agree to pay my treatment plan fees in_____monthly payments of $_____, and any unknown difference based on insurance payment, beginning on_____, with the remaining payments due by_____.

If I fail to do so, I understand that I am responsible for any collection fees (40% of entire balance) or attorney fees incurred, in addition to the remaining balance.

This is our estimated schedule of fees. Any difference in actual balance due is the responsibility of the patient.

Signature _____ Date: _____

Office Manager _____ Date: _____